_____ BILL NO. _____

INTRODUCED BY _____
(Primary Sponsor)

A BILL FOR AN ACT ENTITLED: "AN ACT CREATING THE HEALTH CARE PROVIDER'S RIGHTS OF CONSCIENCE ACT; ALLOWING A HEALTH CARE INSTITUTION, PAYOR, OR PROVIDER TO REFUSE TO PERFORM A HEALTH CARE SERVICE BASED UPON A RELIGIOUS, MORAL, PHILOSOPHICAL, OR ETHICAL CONVICTION OF THE INSTITUTION, PAYOR, OR PROVIDER; PROVIDING FINDINGS AND PURPOSE; PROVIDING DEFINITIONS; PROVIDING FOR IMMUNITY; PROHIBITING DISCRIMINATION AGAINST OR THE DENIAL OF AID OR BENEFIT TO A HEALTH CARE INSTITUTION, PAYOR, OR PROVIDER WHO REFUSES TO PERFORM A HEALTH CARE SERVICE; REQUIRING NOTICE THAT A HEALTH CARE INSTITUTION, PAYOR, OR PROVIDER MAY REFUSE TO PERFORM A HEALTH CARE SERVICE; PROVIDING FOR A PRIVATE RIGHT OF ACTION; AND AMENDING SECTIONS 33-22-131, 33-22-132, 33-22-133, 33-22-134, 33-22-135, 33-22-301, 33-22-303, 33-22-504, 33-22-512, 33-22-522, 33-22-701, 33-22-703, 33-22-704, 33-22-905, 33-22-1002, 33-22-1521, 33-22-1827, AND 33-22-1828, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 33-22-131, MCA, is amended to read:

"33-22-131. Coverage for treatment of inborn errors of metabolism. (1) ~~Each~~ Except as provided in [sections 19 through 25], each group or individual medical expense disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which medically standard methods of diagnosis, treatment, and monitoring exist.

(2) ~~Coverage~~ Except as provided in [sections 19 through 25], coverage must include expenses of diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment, including but not limited to clinical services, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

(3) For purposes of this section:

(a) "medical foods" means nutritional substances in any form that are:

(i) formulated to be consumed or administered enterally under supervision of a physician;

(ii) specifically processed or formulated to be distinct in one or more nutrients present in natural food;

(iii) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirements as established by medical evaluation; and

(iv) essential to optimize growth, health, and metabolic homeostasis;

(b) "treatment" means licensed professional medical services under the supervision of a physician.

(4) These services are subject to the terms of the applicable group or individual disability policy, certificate, or membership contract that establishes durational limits, dollar limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(5) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 2. Section 33-22-132, MCA, is amended to read:

"33-22-132. Coverage for mammography examinations. (1) ~~Each~~ Except as provided in [sections 19 through 25], each group or individual medical expense, cancer, and blanket disability policy, certificate of insurance, and membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide minimum mammography examination coverage.

(2) For the purpose of this section, "minimum mammography examination" means:

(a) one baseline mammogram for a woman who is 35 years of age or older and under 40 years of age;

(b) a mammogram every 2 years for any woman who is 40 years of age or older and under 50 years of age or more frequently if recommended by the woman's physician; and

(c) a mammogram each year for a woman who is 50 years of age or older.

(3) A minimum $70 payment or the actual charge if the charge is less than $70 must be made for each mammography examination performed before the application of the terms of the applicable group or individual disability policy, certificate of insurance, or membership contract that establish durational

limits, deductibles, and copayment provisions as long as the terms are not less favorable than for physical illness generally.

(4) This section does not apply to disability income, hospital indemnity, medicare supplement, accident-only, vision, dental, or specified disease policies."

Section 3. Section 33-22-133, MCA, is amended to read:

"33-22-133. Coverage for minimum hospital stay following childbirth. (1) For the purposes of this section, "attending health care provider" means a person licensed under Title 37 who is responsible for providing obstetrical and pediatric care to a mother and newborn infant.

(2) ~~Each~~ Except as provided in [sections 19 through 25], each group or individual policy, certificate of disability insurance, subscriber contract, membership contract, or health care services agreement that provides coverage for maternity services, including benefits for childbirth, must provide coverage for at least 48 hours of inpatient hospital care following a vaginal delivery and at least 96 hours of inpatient hospital care following delivery by cesarean section for a mother and newborn infant in a health care facility as defined in 50-5-101.

(3) A decision to shorten the length of inpatient stay to less than that provided under subsection (2) must be made by the attending health care provider and the mother. A health benefit plan, as defined in 33-22-1803, may not terminate the service of an attending health care provider or penalize or otherwise provide financial disincentives to an attending health care provider in response to orders by the attending health care provider for care consistent with the provisions of this section.

(4) A health benefit plan that provides coverage for postdelivery care that is provided to a mother and newborn infant in the home may not be required to provide coverage of inpatient care under subsection (2) unless the inpatient care is determined to be medically necessary by the attending health care provider.

(5) A health benefit plan, as defined in 33-22-243, must provide written notice, in a manner consistent with the provisions of this chapter, to all enrollees, insureds, or subscribers regarding the coverage required by this section."

Section 4. Section 33-22-134, MCA, is amended to read:

"33-22-134. Postmastectomy care. ~~Each~~ Except as provided in [sections 19 through 25], each

group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for hospital inpatient care for a period of time as is determined by the attending physician and, in the case of a health maintenance organization, also the primary care physician, in consultation with the patient, to be medically necessary following a mastectomy, a lumpectomy, or a lymph node dissection for the treatment of breast cancer. This section also applies to the state employee group insurance program, the university system employee group insurance program, any employee group insurance program of a city, town, county, school district, or other political subdivision of the state, and any self-funded multiple employer welfare arrangement that is not regulated by the Employee Retirement Income Security Act of 1974."

Section 5. Section 33-22-135, MCA, is amended to read:

"33-22-135. Coverage for reconstructive breast surgery after mastectomy. (1) ~~Each~~ Except as provided in [sections 19 through 25], each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for reconstructive breast surgery resulting from a mastectomy that resulted from breast cancer.

(2) ~~Each~~ Except as provided in [sections 19 through 25], each group and individual disability policy, certificate of insurance, or membership contract that is delivered, issued for delivery, renewed, extended, or modified in this state must provide coverage for all stages of one reconstructive breast surgery on the nondiseased breast to establish symmetry with the diseased breast after definitive reconstructive breast surgery on the diseased breast has been performed.

(3) For the purposes of this section:

(a) "mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer;

(b) "reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the breasts. The term includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

(4) ~~Benefits~~ Except as provided in [sections 19 through 25], benefits for reconstructive breast surgery include but are not limited to the costs of prostheses and, under any contract providing outpatient x-ray or radiation therapy, benefits for outpatient chemotherapy following surgical procedures in connection with the treatment of breast cancer that must be included as a part of the outpatient x-ray or

radiation therapy benefit."

Section 6. Section 33-22-301, MCA, is amended to read:

"33-22-301. Coverage of newborn under disability policy. (1) ~~Each~~ Except as provided in [sections 19 through 25], each policy of disability insurance or certificate issued must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any insured.

(2) ~~The~~ Except as provided in [sections 19 through 25], the coverage for newborn infants must be the same as provided by the policy for the other covered persons. However, ~~that~~ for newborn infants there may not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(3) ~~A~~ Except as provided in [sections 19 through 25], a policy or certificate of insurance may not be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth.

(4) The policy or contract may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 7. Section 33-22-303, MCA, is amended to read:

"33-22-303. Coverage for well-child care. (1) ~~Each~~ Except as provided in [sections 19 through 25], each medical expense policy of disability insurance or certificate issued under the policy that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 2 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) ~~Coverage~~ Except as provided in [sections 19 through 25], coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a policy of disability insurance or a certificate issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

Section 8. Section 33-22-504, MCA, is amended to read:

"33-22-504. Newborn infant coverage. (1) ~~A~~ Except as provided in [sections 19 through 25], a group disability policy or certificate of insurance delivered or issued for delivery in this state may not be issued or amended in this state if it contains any disclaimer, waiver, preexisting condition exclusion, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of persons covered under the policy from and after the moment of birth.

(2) ~~A~~ Except as provided in [sections 19 through 25], a policy or certificate subject to this section, must contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any person covered under the policy.

(3) ~~The~~ Except as provided in [sections 19 through 25], the coverage for newborn infants must be the same as provided by the policy for other covered persons. However, for newborn infants there may

not be waiting or elimination periods. A deductible or reduction in benefits applicable to the coverage for newborn infants is not permissible unless it conforms and is consistent with the deductible or reduction in benefits applicable to all other covered persons.

(4) This section does not apply to medicare supplement policies issued by reason of age.

(5) When a group disability policy or certificate issued under the policy provides for coverage or benefits for a resident of this state, the policy or certificate is considered delivered in this state within the meaning of this section regardless of whether the insurer issuing the policy or certificate is located in this state.

(6) The policy or certificate may require notification of the birth of a child and payment of a required premium or subscription fee to be furnished to the insurer or nonprofit or indemnity corporation within 31 days of the birth in order to have the coverage extend beyond 31 days."

Section 9. Section 33-22-512, MCA, is amended to read:

"33-22-512. Coverage for well-child care. (1) ~~Each~~ Except as provided in [sections 19 through 25], each group disability policy or certificate of insurance that is delivered, issued for delivery, renewed, extended, or modified in this state by a disability insurer and that provides coverage for a family member of the insured or subscriber must provide coverage for well-child care for children from the moment of birth through 2 years of age. Benefits provided under this coverage are exempt from any deductible provision that may be in force in the policy or certificate issued under the policy.

(2) ~~Coverage~~ Except as provided in [sections 19 through 25], coverage for well-child care under subsection (1) must include:

(a) a history, physical examination, developmental assessment, anticipatory guidance, and laboratory tests, according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in 53-6-101; and

(b) routine immunizations according to the schedule for immunizations recommended by the immunization practices advisory committee of the U.S. department of health and human services.

(3) Minimum benefits may be limited to one visit payable to one provider for all of the services provided at each visit cited in this section.

(4) This section does not apply to disability income, specified disease, medicare supplement, or hospital indemnity policies.

(5) For purposes of this section:

(a) "well-child care" means the services described in subsection (2) and delivered by a physician or a health care professional supervised by a physician; and

(b) "developmental assessment" and "anticipatory guidance" mean the services described in the Guidelines for Health Supervision II, published by the American academy of pediatrics.

(6) When a group disability policy or certificate of insurance issued under the policy provides coverage or benefits to a resident of this state, it is considered to be delivered in this state within the meaning of this section, whether the insurer that issued or delivered the policy or certificate is located inside or outside of this state."

Section 10. Section 33-22-522, MCA, is amended to read:

"33-22-522. Uniform health benefit plan -- group. (1) ~~Each~~ Except as provided in [sections 19 through 25], each insurer or health service corporation delivering or issuing for delivery in this state a health benefit plan, as defined in 33-22-243, to a group shall make available a uniform health benefit plan providing the benefits and services required in subsection (2).

(2) ~~The~~ Except as provided in [sections 19 through 25], the uniform health benefit plan must:

(a) provide coverage for the services and articles required by 33-22-1521(2);

(b) pay 50% of the covered expenses in excess of an annual deductible that may not exceed $1,000 per person or $2,000 per family;

(c) include a limitation of $5,000 per person or $7,500 per family on the total annual out-of-pocket expenses for services covered; and

(d) be subject to a maximum lifetime benefit of $1 million.

(3) Except as provided in this section, a health insurance issuer may exclude any category of licensed health care practitioner and any benefit or coverage for health care services otherwise required by law or rule from a group uniform health benefit plan delivered or issued for delivery in this state."

Section 11. Section 33-22-701, MCA, is amended to read:

"33-22-701. Scope of part -- purpose -- exception. Except as provided in 33-22-706 and in [sections 19 through 25], the provisions of this part apply to all group policies of accident and health insurance and group subscriber contracts for the care and treatment of mental illness, alcoholism, and drug

addiction offered to Montana residents by insurers, health service corporations, and all employees' health and welfare funds that provide accident and health insurance benefits to residents of this state. It is the purpose of this part to preserve the rights of the consumer to have this coverage according to the consumer's medical and economic needs."

Section 12. Section 33-22-703, MCA, is amended to read:

"33-22-703. (Temporary) Coverage for mental illness, alcoholism, and drug addiction. (1) ~~A~~ Except as provided in [sections 19 through 25], a group health plan or a health insurance issuer that provides group health insurance coverage shall provide for Montana residents covered by the plan at least the following level of benefits for the necessary care and treatment of mental illness, alcoholism, and drug addiction:

(a) under basic inpatient expense policies or contracts, inpatient hospital benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(i) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(ii) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

(iii) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000; and

(iv) costs for medical detoxification treatment must be paid the same as any other sickness or illness under the terms of the contract and are not subject to the annual and lifetime limits in subsection (1)(a)(iii);

(b) under major medical policies or contracts, inpatient benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(i) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(ii) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

(iii) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, may be subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000;

(iv) costs for medical detoxification treatment, which must be paid the same as any other illness under the terms of the contract and are not subject to the annual and lifetime benefits in subsection (1)(b)(iii)~~;~~ and~~;~~

(v) outpatient treatment for mental illness may be subject to a maximum yearly benefit of no less than $2,000, but this subsection (1)(b)(v) does not apply to benefits for services furnished before September 30, 2001, unless the group health plan or group health insurance coverage is exempt from the requirements of subsection (2) pursuant to subsection (3) or (4).

(2) ~~A~~ Except as provided in [sections 19 through 25], a group health plan or group health insurance coverage offered in connection with a group health plan may not impose an aggregate dollar limit on an annual or lifetime basis more restrictively for mental health benefits than for medical and surgical benefits covered by the plans. In the case of a plan that has different aggregate lifetime limits and different annual limits on various categories of medical and surgical benefits, the commissioner shall establish rules for determining a weighted average aggregate lifetime limit and weighted average annual limit to apply to mental health benefits. This subsection does not apply to benefits for services furnished on or after September 30, 2001.

(3) Subsection (2) does not apply to a group health plan or health insurance coverage offered in connection with a group health plan in the small group market.

(4) Subsection (2) does not apply to a group health plan or health insurance coverage offered in connection with a group health plan if the application of subsection (2) results in an increase in the cost under the group health plan or for coverage of at least 1%. This subsection applies separately to each benefit package option in the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the group health plan. (Terminates September 30, 2001--sec. 54, Ch.

416, L. 1997.)

33-22-703. (Effective October 1, 2001) Coverage for mental illness, alcoholism, and drug addiction. ~~A~~ Except as provided in [sections 19 through 25], a group health plan or a health insurance issuer that provides group health insurance coverage shall provide for Montana residents covered by the plan at least the following level of benefits for the necessary care and treatment of mental illness, alcoholism, and drug addiction:

(1) under basic inpatient expense policies or contracts, inpatient hospital benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(a) inpatient treatment for mental illness is subject to a maximum yearly benefit of 21 days;

(b) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

(c) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for medical detoxification, is subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000; and~~;~~

(d) costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the annual and lifetime limits in subsection (1)(c);

(2) under major medical policies or contracts, inpatient benefits and outpatient benefits consisting of durational limits, dollar limits, deductibles, and coinsurance factors that are not less favorable than for physical illness generally, except that:

(a) inpatient treatment for mental illness, alcoholism, and drug addiction is subject to a maximum yearly benefit of 21 days;

(b) inpatient treatment for mental illness may be traded on a 2-for-1 basis for a benefit for partial hospitalization through a program that complies with the standards for a partial hospitalization program that are published by the American association for partial hospitalization if the program is operated by a hospital;

(c) inpatient and outpatient treatment for alcoholism and drug addiction, excluding costs for

medical detoxification, may be subject to a maximum benefit of $6,000 for a 12-month period until a lifetime maximum inpatient benefit of $12,000 is met, after which the annual benefit may be reduced to $2,000;

(d) costs for medical detoxification treatment must be paid the same as any other illness under the terms of the contract and are not subject to the annual and lifetime benefits in subsection (2)(c) and;

(e) outpatient treatment for mental illness may be subject to a maximum yearly benefit of no less than $2,000, but this subsection (2)(e) does not apply to benefits for services furnished before September 30, 2001."

Section 13. Section 33-22-704, MCA, is amended to read:

"33-22-704. Applicability. Except as provided in 33-22-706 and in [sections 19 through 25], this part applies to policies, contracts, or any employees' health and welfare fund that provides accident and health insurance benefits, established, delivered, issued for delivery, or renewed after September 30, 1987, but does not apply to blanket, short-term travel, accident-only, limited or specified disease, individual conversion policies or contracts, or to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as medicare, or any other similar coverage under state or federal governmental plans."

Section 14. Section 33-22-905, MCA, is amended to read:

"33-22-905. Minimum standards for benefits and payment of claims -- rules. The commissioner shall adopt reasonable rules to establish minimum standards for benefits, payment of claims, marketing practices, compensation arrangements, and reporting practices for medicare supplement policies and certificates. [Sections 19 through 25] apply to benefits required by the rules of the commissioner."

Section 15. Section 33-22-1002, MCA, is amended to read:

"33-22-1002. Availability of coverage for home health care. ~~Insurers~~ Except as provided in [sections 19 through 25], insurers and health services corporations transacting health insurance business in this state ~~must~~ shall make available, under group insurance policies and under group hospital and medical service plan contracts, benefits for home health care. Applicants for a group policy or contract may select any level of benefits ~~as~~ that may be offered by the insurer or health service ~~plan~~ corporation."

Section 16. Section 33-22-1521, MCA, is amended to read:

"33-22-1521. Association plan -- minimum benefits. A plan of health coverage must be certified as an association plan if it otherwise meets the requirements of Title 33, chapters 15, 22 (excepting part 7), and 30, and other laws of this state, whether or not the policy is issued in this state, and meets or exceeds the following minimum standards:

(1) (a) The minimum benefits for an insured must, subject to the other provisions of this section, be equal to at least 50% of the covered expenses required by this section in excess of an annual deductible that does not exceed $1,000 per person. The coverage must include a limitation of $5,000 per person on the total annual out-of-pocket expenses for services covered under this section. Coverage must be subject to a maximum lifetime benefit, but the maximums may not be less than $100,000.

(b) One association plan must be offered with coverage for 80% of the covered expenses provided in this section in excess of an annual deductible that does not exceed $1,000 per person. This association plan must provide a maximum lifetime benefit of at least $500,000.

(c) Covered expenses for plans under subsection (1)(a) and (1)(b) must be paid as specified in provider contracts or, in the absence of a provider contract, at the prevailing charge in the state where the service is provided.

(d) The board may authorize other association plans, including managed care plans as defined in 33-36-103.

(2) ~~Covered~~ Except as provided in [sections 19 through 25], covered expenses for plans offered under subsections (1)(a) and (1)(b) must be for the following medically necessary services and articles when prescribed by a physician or other licensed health care professional and when designated in the contract:

(a) hospital services;

(b) professional services for the diagnosis or treatment of injuries, illness, or conditions, other than dental;

(c) use of radium or other radioactive materials;

(d) oxygen;

(e) anesthetics;

(f) diagnostic x-rays and laboratory tests, except as specifically provided in subsection (3);

(g) services of a physical therapist;

(h) transportation provided by licensed ambulance service to the nearest facility qualified to treat the condition;

(i) oral surgery for the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth or in connection with TMJ;

(j) rental or purchase of durable medical equipment, which must be reimbursed after the deductible has been met at the rate of 50%, up to a maximum of $1,000;

(k) prosthetics, other than dental;

(l) services of a licensed home health agency, up to a maximum of 180 visits per year;

(m) drugs requiring a physician's prescription that are approved for use in human beings in the manner prescribed by the United States food and drug administration, covered at 50% of the expense, up to an annual maximum of $1,000;

(n) medically necessary, nonexperimental transplants of the kidney, pancreas, heart, heart/lung, lungs, liver, cornea, and high-dose chemotherapy bone marrow transplantation, limited to a lifetime maximum of $150,000, with an additional benefit not to exceed $10,000 for expenses associated with the donor;

(o) pregnancy, including complications of pregnancy;

(p) newborn infant coverage, as required by 33-22-301;

(q) sterilization;

(r) immunizations;

(s) outpatient rehabilitation therapy;

(t) foot care for diabetics;

(u) services of a convalescent home, as an alternative to hospital services, limited to a maximum of 60 days per year; and

(v) travel, other than transportation by a licensed ambulance service, to the nearest facility qualified to treat the patients medical condition when approved in advance by the insurer.

(3) (a) Covered expenses for the services or articles specified in this section do not include:

(i) home and office calls, except as specifically provided in subsection (2);

(ii) rental or purchase of durable medical equipment, except as specifically provided in subsection (2);

(iii) the first $20 of diagnostic x-ray and laboratory charges in each 14-day period;

(iv) oral surgery, except as specifically provided in subsection (2);

(v) that part of a charge for services or articles that exceeds the prevailing charge in the state where the service is provided; or

(vi) care that is primarily for custodial or domiciliary purposes that would not qualify as eligible services under medicare.

(b) Covered expenses for the services or articles specified in this section do not include charges for:

(i) care or for any injury or disease arising out of an injury in the course of employment and subject to a workers' compensation or similar law, for which benefits are payable under another policy of disability insurance or medicare;

(ii) treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or congenital bodily defect to restore normal bodily functions;

(iii) travel other than transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition, except as provided by subsection (2);

(iv) confinement in a private room to the extent that it is in excess of the institution's charge for its most common semiprivate room, unless the private room is prescribed as medically necessary by a physician;

(v) services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or articles;

(vi) room and board for a nonemergency admission on Friday or Saturday;

(vii) routine well baby care;

(viii) complications to a newborn, unless no other source of coverage is available;

(ix) reversal of sterilization;

(x) abortion, unless the life of the mother would be endangered if the fetus were carried to term;

(xi) weight modification or modification of the body to improve the mental or emotional well-being of an insured;

(xii) artificial insemination or treatment for infertility; or

(xiii) breast augmentation or reduction."

Section 17. Section 33-22-1827, MCA, is amended to read:

"33-22-1827. Benefits required in basic health benefit plan. (1) ~~The~~ Except as provided in [sections 19 through 25], the basic health benefit plan must provide at least the following benefits:

(a) coverage for the services and articles required by 33-22-1521(2);

(b) coverage for mental health and chemical dependency required by Title 33, chapter 22, part 7;

(c) coverage for conversion of benefits required by 33-22-508 and 33-22-510 or by 33-30-1007; and

(d) coverage for mammography examinations required by 33-22-132.

(2) The small employer carrier may determine varying levels of deductibles, copayments, maximum annual out-of-pocket expenses, maximum lifetime benefits, and other financial cost-sharing arrangements with the insured that give the basic health benefit plan a lower benefit value than the standard health benefit plan.

(3) A basic health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsections (1) and (2), as determined by the benefit value."

Section 18. Section 33-22-1828, MCA, is amended to read:

"33-22-1828. Benefits required in standard benefit plan. (1) The minimum benefits must be equal to at least 75% of the covered expenses in excess of an annual deductible that does not exceed $500 per person or $1,000 per family. The coverage must include a limitation of $2,000 per person or $4,000 per family on the total annual out-of-pocket expenses for services covered. The coverage may be subject to a maximum lifetime benefit, but a maximum, if any, may not be less than $1 million.

(2) The commissioner may not require coverage in a standard health benefit plan for any benefit unless other provisions of Title 33, chapter 22, 30, or 31, specifically require coverage for the benefit. Benefits required by the commissioner are subject to [sections 19 through 25]. A small employer carrier may offer coverage for additional services and articles.

(3) ~~A~~ Except as provided in [sections 19 through 25], a standard health benefit plan provided by a health maintenance organization or a basic health benefit plan with a restricted network provision must provide a comparable level of benefits to those required by subsection (1), as determined by the benefit

value."

NEW SECTION. **Section 19. Short title.** [Sections 19 through 25] may be cited as the "Health Care Provider's Rights of Conscience Act".

NEW SECTION. **Section 20. Findings and purpose.** (1) The legislature declares that it is the public policy of Montana to respect and protect the fundamental rights of conscience of all individuals and entities involved in providing health care services.

(2) Without a comprehensive civil rights act for health care providers, health care institutions, and health care payors, religious beliefs and rights of conscience may be violated in various ways, such as harassment, demotion, salary reduction, transfer, termination, loss of staffing privileges, denial of aid or benefits, or refusal to license or certify.

(3) It is the purpose of [sections 19 through 25] to protect as a basic civil right the right of all health care providers, health care institutions, and health care payors to refuse to counsel, advise, pay for, provide, perform, assist, or participate in, directly or indirectly, providing or performing a health care service that violates the health care provider's, health care institution's, or health care payor's religious, moral, philosophical, or ethical convictions. Those health care services may include but are not limited to abortion, artificial insemination, assisted reproduction, artificial birth control, cloning, human stem cell and fetal experimentation, withdrawal of nutrition and hydration, physician-assisted suicide, and euthanasia. The listing of a health care service in this subsection does not imply approval to perform a listed service.

(4) Accordingly, it is the purpose of [sections 19 through 25] to prohibit all forms of discrimination, disqualification, coercion, disability, or liability upon individuals or health care institutions who refuse to perform a health care service based on religious, moral, philosophical, or ethical convictions.

NEW SECTION. **Section 21. Definitions.** As used in [sections 19 through 25], the following definitions apply:

(1) "Discrimination" means termination, transfer, refusal of staff privileges at a health care institution, refusal of board certification, administrative action, demotion, loss of career specialty, reassignment to a different shift, reduction of wages or benefits, refusal to award a grant, contract, or other program, refusal to provide standard residency training opportunities, or any other penalty or

disciplinary or retaliatory action.

(2) "Health care institution" means a public or private organization, corporation, partnership, sole proprietorship, association, agency, network, joint venture, or other legal entity that is involved in providing a health care service. The term includes but is not limited to hospitals, clinics, medical centers, ambulatory surgical centers, private physician's offices, pharmacies, nursing homes, university medical schools and nursing schools, medical training facilities, or other institutions or locations in which health care services are provided to an individual.

(3) "Health care payor" means an entity or financing organization, including but not limited to a health maintenance organization, insurance company, management services organization, or employer, that pays or arranges for the payment of a health care service or product used in the provision of the health care service.

(4) "Health care provider" means an individual who may be asked to directly or indirectly participate in any way in a health care service. The term includes but is not limited to a physician, physician's assistant-certified, nurse, nurse's aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, medical or nursing school faculty, student, or employee, chaplain, counselor, social worker, volunteer, or any professional, paraprofessional, or other individual who furnishes or assists in the furnishing of a health care service.

(5) "Health care service" means the direct or indirect provision of or assisting with any phase of patient medical care, treatment, or procedure, whether before or after the fact, including but not limited to patient referrals, patient counseling, patient therapy, patient testing, patient diagnosis or prognosis, research, instruction, the prescription or administration of any device, drug, or medication or any combination of drugs or medications, performing surgery, or providing any other care or treatment rendered by health care providers or health care institutions that is intended to provide for the patient's physical, mental, emotional, or spiritual well-being.

(6) "Religious, moral, philosophical, or ethical convictions" means the religious, moral, philosophical, or ethical principles sincerely believed by a health care provider or the policies adopted by the governing body of a health care institution or health care payor that are based on sincerely held religious, moral, philosophical, or ethical principles.

NEW SECTION. **Section 22. Rights of conscience of health care providers -- immunity --**

discrimination -- required notice. (1) A health care provider may refuse to counsel, advise, pay for, provide, perform, assist, or participate, directly or indirectly, in providing or performing a health care service, including a health care service otherwise required by law to be performed, that violates the provider's religious, moral, philosophical, or ethical convictions. A health care provider may not be required to counsel, advise, pay for, provide, perform, assist, or participate, directly or indirectly, in providing or performing a health care service that violates the provider's religious, moral, philosophical, or ethical convictions.

(2) A health care provider may not be held civilly, criminally, or administratively liable for a refusal to counsel, advise, pay for, provide, perform, assist, or participate, directly or indirectly, in providing or performing a healthcare service that violates the health care provider's religious, moral, philosophical, or ethical convictions if:

(a) prior to the request or assignment, the health care provider has notified the person making the request or assignment of the health care provider's general refusal and, if asked, has given that general refusal in writing; or

(b) the health care provider notified the person making the request or assignment of the health care provider's refusal within 24 hours after being asked or assigned.

(3) A person, health care provider, health care institution, public or private institution, public official, or certifying board that certifies competency in medical specialties may not discriminate against a health care provider in any manner based on the health care provider's refusal to participate in a health care service.

(4) No later than November 1, 2001, a health care institution shall post the following notice in a location that is conspicuous to health care providers and also include the notice in any policy manuals used by the institution.

Notice of Health Care Provider's Rights of Conscience

State law permits a health care provider to refuse to participate in any type of health care service based on the provider's religious, moral, ethical, or philosophical convictions.

A health care provider may not be held civilly, criminally, or administratively liable for a refusal to counsel, advise, pay for, provide, perform, assist, or participate, directly or indirectly, in providing or performing a health care service that violates the provider's religious, moral, ethical, or philosophical convictions if:

(1) prior to the request or assignment, the health care provider notified the person making the request or assignment of the health care provider's general refusal and, if asked, gave that general refusal in writing to the person making the request or assignment; or

(2) the health care provider notified the person making the request or assignment of the health care provider's refusal within 24 hours after being asked or assigned.

In accordance with the Health Care Provider's Rights of Conscience Act, published in [sections 19 through 25], MCA, it is unlawful for a individual or institution to discriminate against, discipline, or take any other retaliatory action against a health care provider who exercises the health care provider's right to refuse to participate in a health care service. State law provides specific civil remedies for the violation of the Health Care Provider's Rights of Conscience Act, in [section 25], MCA. "Health care provider", as defined in state law, means an individual who may be asked to directly or indirectly participate in any way in a health care service and includes but is not limited to a physician, physician's assistant-certified, nurse, nurse's aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, medical or nursing school faculty, student, or employee, chaplain, counselor, social worker, volunteer, or any professional, paraprofessional, or other person who furnishes or assists in the furnishing of a health care service.

(5) A health care institution that fails to post the notice provided in subsection (4) in the manner required by this section is subject to a civil penalty of $500 for each violation. The penalty may be collected by the department of public health and human services after an opportunity for a hearing pursuant to the Montana Administrative Procedure Act. The department may bring an action in the district court of Lewis and Clark county against a health care institution failing to pay the civil penalty to the department.

NEW SECTION. **Section 23. Rights of conscience of health care institutions -- immunity -- discrimination or denial of benefits prohibited.** (1) A health care institution may refuse to counsel, advise, pay for, provide, perform, assist, or participate, directly or indirectly, in providing or performing a health care service that violates the health care institution's religious, moral, philosophical, or ethical convictions. A health care institution is not required to counsel, advise, pay for, provide, perform, assist, or participate, directly or indirectly, in providing or performing a health care service, including but not limited to admitting a person to the institution with the purpose of providing health care services that violate the health care

institution's policies adopted by its governing body that are based on religious, moral, philosophical, or ethical convictions.

(2) A health care institution may not be held civilly, criminally, or administratively liable to any person for a refusal pursuant to subsection (1) if:

(a) the health care institution posted notice of its refusal policy in plain sight in the admission area of the health care institution prior to the request or assignment; or

(b) the health care institution notified the person requesting the health care service of its refusal within 24 hours of the request.

(3) A person, public or private institution, or public official may not discriminate against a person, association, or corporation attempting to establish a new health care institution or operating an existing health care institution, in any manner, including but not limited to any denial, deprivation or disqualification in licensing, the granting of authorizations, aid, assistance, benefits, medical staff or any other privileges, or the granting of authorization to expand, improve, merge, or create any health care institution, because of a refusal of the person, association, or corporation planning, proposing to operate, or operating a health care institution, to permit or perform particular health care service that violate the health care institution's religious, moral, philosophical, or ethical convictions, as documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other documents governing the operation of the health care institution.

(4) A public official, agency, institution, or entity may not deny any form of aid, assistance, grants, or benefits or in any other manner coerce, disqualify, or discriminate against a person, association, or corporation attempting to establish a new health care institution or operating an existing health care institution that otherwise would be entitled to the aid, assistance, grant, or benefits because the existing or proposed health care institution refuses to perform, assist, counsel, suggest, recommend, refer, or participate in any way in any form of health care service contrary to the health care institution's religious, moral, philosophical, or ethical convictions, as documented in its existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other documents governing the operation of the institution.

NEW SECTION. **Section 24. Rights of conscience of health care payors -- immunity -- discrimination or denial of benefits prohibited.** (1) A health care payor may refuse to pay or arrange for the

payment of a health care service or product that violates the payor's policies adopted by its governing body that are based on religious, moral, philosophical, or ethical convictions.

(2) A health care payor or a person, association, or corporation that owns, operates, supervises, or manages a health care payor may not be held civilly or criminally liable to any person, estate, or public or private entity because of a refusal of the health care payor to pay for or arrange for the payment of any particular health care services that violate the health care payor's religious, moral, philosophical, or ethical convictions, as documented in its ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other documents governing the operation of the health care payor.

(3) A person, public or private institution, or public official may not discriminate against a person, association, or corporation attempting to establish a new health care payor or operating an existing health care payor, in any manner, including but not limited to any denial, deprivation, or disqualification in licensing, the granting of authorizations, aid, assistance, benefits, or any other privilege, or the granting of authorization to expand, improve, merge, or create any health care payor, because the person, association, or corporation planning, proposing to operate, or operating a health care payor refuses to pay for or arrange for the payment of any particular health care service that violate the health care payor's religious, moral, philosophical, or ethical convictions, as documented in the existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other documents governing the operation of the health care payor.

(4) A public official, agency, institution, or entity may not deny any form of aid, assistance, grants, or benefits or in any other manner coerce, disqualify, or discriminate against a person, association, or corporation attempting to establish a new health care payor or operating an existing health care payor that otherwise would be entitled to the aid, assistance, grant, or benefit because the existing or proposed health care payor refuses to pay for, arrange for the payment of, or participate in any way in particular health care services contrary to the health care payor's religious, moral, philosophical, or ethical convictions, as documented in the existing or proposed ethical guidelines, mission statement, constitution, bylaws, articles of incorporation, regulations, or other documents governing the operation of the payor.

NEW SECTION. **Section 25. Civil remedies.** (1) A civil action for damages or injunctive relief, or both, may be brought for the violation of a provision of [sections 19 through 25]. It is not a defense to a claim arising out of a violation of [sections 19 through 25] that the violation was necessary to prevent

an additional burden or expense on another health care provider, health care institution, individual, or patient.

(2) An individual, association, corporation, entity, or health care institution injured by an individual or a public or private association, agency, entity, or corporation violating a provision of [sections 19 through 25] may bring a civil action based on the violation. The party bringing the action may recover three times the party's actual damages, including pain and suffering, sustained by the individual, association, corporation, entity, or health care institution, the costs of the action, and reasonable attorney fees, but recovery may not be less than $5,000 for each violation, in addition to costs of the action and reasonable attorney fees. Damages allowed by this section are cumulative and not exclusive of other remedies afforded under another state or federal law.

(3) The court may award injunctive relief pursuant to Title 27, chapter 19, to prevent or remedy a violation of a provision of [sections 19 through 25], including but not limited to ordering reinstatement of a health care provider to the health care provider's prior employment.

NEW SECTION. **Section 26. Two-thirds vote required.** Because [sections 22 through 24] limit government liability, Article II, section 18, of the Montana constitution requires a vote of two-thirds of the members of each house of the legislature for passage.

NEW SECTION. **Section 27. Codification instruction.** [Sections 19 through 25] are intended to be codified as an integral part of Title 37, chapter 2, and the provisions of Title 37, chapter 2, apply to [sections 19 through 25].

NEW SECTION. **Section 28. Saving clause.** [This act] does not affect rights and duties that matured, penalties that were incurred, or proceedings that were begun before October 1, 2001.

NEW SECTION. **Section 29. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

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